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Tuberculosis Clinic Record

Spokane Regional Health District

SPOKANE REGIONAL HEALTH DISTRICT

Lab #: _____ KIPHS # _____

Last Name: _____ First: _____ MI: ____ Birthdate: _____ Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternative Phone: _____ SS#: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Separated Gender: ☐ Female ☐ Male

Medicaid Eligible? ☐ Yes ☐ No If Yes, copy provided to Client Services. ☐ Yes By: _____ (initials)

Insurance Coverage? ☐ Yes ☐ No If Yes, Who: _____ Paid Rx Coverage? ☐ Yes ☐ No

Race/Ethnicity:

☐ White ☐ Asian _____ (specify)

☐ Black

☐ Hispanic ☐ Pacific Islander _____ (specify)

☐ Alaskan Native

☐ Native Hawaiian ☐ Native American _____ (tribe)

Primary Language - English?: ☐ Yes ☐ No

If No, _____ (specify) interpreter needed.

Occupation:

☐ Unemployed >24 MOS
☐ Corrections Employee
☐ Migrant Farm Worker
☐ Retired
☐ Healthcare
☐ Other (Specify):

☐ Employer's Name:

Risk Factors: (mark all that apply)

☐ None ☐ History of incarceration ☐ Immunosuppressed
☐ HIV ☐ Homelessness ☐ End Stage of Renal Disease
☐ Silicosis ☐ Diabetes Mellitus ☐ Intestinal Bypass
☐ History of injection drug use/substance abuse
☐ Blood Disorder (Myeloproliferative disorders, leukemias, lymphomas?)
☐ Cancer
If yes, what was the location? ☐ Head ☐ Neck ☐ Lung ☐ Other*
*Please List: _____

☐ Refugee camp If yes:Where? _____
How long? _____

☐ Foreign-borne Country of Origin: _____
Month & Year of Arrival: _____

Class: ☐ A ☐ B1 ☐ B2 Alien #: _____

Risk Factors for Liver Toxicity

☐ None ☐ Alcohol (> 10 drinks/week)
☐ Chronic Liver Disease ☐ Hepatitis B Vaccine Series
☐ Hx Hepatitis B or C (Please Check) ☐ Hep B ☐ Hep C
☐ Other: _____

HIV Risk Assessment:

Been Tested? ☐ Yes ☐ No
If yes, when? _____
Referred for testing? ☐ Yes ☐ No
If yes, where? _____

Risk Factors Assessed? (IDU, MSM, Prtnr HIV+,Sex for $/Drugs) ☐ Yes ☐ No

Current Medications: (Specify Name, Dose &Frequency)

☐ None
☐ Steroids: _____
☐ Antiseizure Meds: _____
☐ Anticoagulants: _____
☐ Methadone: _____
☐ Tumor Necrosis Factor Alpha _____
☐ Other Medications:

☐ Allergies:

☐ No Known Allergies

Current Symptoms:

☐ None
☐ Cough If yes, how long? _____ Productive? ☐ Yes ☐ No
☐ Hemoptysis (blood in sputum) If yes, how long? _____
☐ Fever If yes, how long? _____
☐ Night Sweats If yes, how long? _____
☐ Unusual Fatigue If yes, how long? _____
☐ Weight Loss If yes, how much? _____
☐ Anorexia (loss of appetite) If yes, how long? _____
☐ Dyspnea (shortness of breath) If yes, how long? _____
☐ Chest Pain If yes, any history of heart pbs? _____
☐ Hoarseness If yes, how long? _____
☐ Any Other Health Pbs. _____

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Tuberculosis History

History of BCG:
☐ Yes
☐ No
If yes, when?

Testing:
☐ Skin
PPD Applied: (Date)
PPD Read: (Date)
Results: mm
Facility:

☐ QFT-G
Blood Draw: (Date)
Results:

Previous Diagnosis of TB:
☐ NO
☐ Latent, untreated Year DX:
☐ Latent, treated Year DX:
Medications:
☐ Active, untreated Year DX:
☐ Active, treated Year DX:
Medications:

Reason for Referral:
☐ Symptoms of TB
☐ Refugee/Immigration Exam
☐ Contact to Case: (name)
☐ TB Suspect Referral (facility)
☐ Drug Tx Program Referral (facility)
☐ Homeless Shelter Referral (facility)
☐ Jail Referral (facility)
☐ PMD Referral
Name:
Phone:
☐ Other

Previous Tests:
PPD:
☐ No
☐ Yes (Date) mm (results)
Facility:
Chest X-ray:
☐ No
☐ Yes (Date) Requested: ☐ Yes ☐ No
Facility:
Other:
(specify type, facility)

Tobacco Use:
☐ Never
☐ Former Packs/day
Quit # Yrs ago
☐ Current Packs/day

Women's Health:
☐ Last Menstrual Period (LMP) (Date)
☐ Post menopause
☐ Pregnant Trimester (check) ☐ 1st ☐ 2nd ☐ 3rd
☐ Contraception Method
☐ Advised to avoid pregnancy

Education & Follow-up

☐ Provided education on TB disease, or latent TB infection.
☐ Discussed medication requirements or recommendations.
☐ Client viewed video on INH.
☐ Sent to Inland Imaging for chest X-ray

☐ Current weight lbs
kgs
☐ TB MD clinic appointment for: (Date/time)

Consent for Treatment:

I consent to examination, diagnostic testing and treatment services provided by the Spokane Regional Health District.

Signature: _____ **Date:** _____

Date: _____ **Nurse signature:** _____

Revised 10/25/2006 for QFT-G screening purposes